CHAPTER 13
SECTION 8.1

RESIDENTIAL TREATMENT CENTER (RTC) REIMBURSEMENT

Issue Date: August 26, 1985
Authority: 32 CFR 199.14(f)

I. ISSUE

How are RTCs to be reimbursed?

II. BACKGROUND

A. Residential Treatment Centers.

1. A residential treatment center (RTC) is a facility or distinct part of a facility that provides, to children and adolescents, a total, twenty-four hour, therapeutically planned group living and learning situation where distinct and individualized psychotherapeutic interventions can take place. Residential treatment is a specific level of care to be differentiated from acute, intermediate and long term hospital care, when the least restrictive environment is maintained to allow for normalization of the patient's surroundings. The RTC must be both physically and programmatically distinct if it is a part or subunit of a larger treatment program. A residential treatment center is organized and professionally staffed to provide residential treatment of mental disorders to children and adolescents who have sufficient intellectual potential to respond to active treatment (that is, for whom it can reasonably be assumed that treatment of the mental disorder will result in an improved ability to function outside the residential treatment center), for whom outpatient treatment, partial hospitalization or other level of inpatient treatment is not appropriate, and for whom a protected and structured environment is medically or psychologically necessary.

2. In order to become TRICARE-authorized providers, RTCs must sign a participation agreement. The agreement, among other things, requires the RTC to accept the TRICARE/CHAMPUS determined rate as payment in full and collect from the TRICARE/CHAMPUS beneficiary or the family of the TRICARE/CHAMPUS beneficiary only those amounts that represent the beneficiary's liability, as defined by regulations, and charges for services and supplies that are not a benefit. The TMA responsibility for execution of the participation agreements has been delegated to the contractor. All participation agreements include the specific rate established for each RTC, and the billing number that must be used for claims submission.

III. POLICY

A. Rate Structure: Determination of Rebased Rate.

The TRICARE rate is the per diem rate that TRICARE will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a TRICARE-approved RTC, and approved by the contractor.

1. The all-inclusive per diem rate for RTCs operating or participating in CHAMPUS during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

a. The CHAMPUS rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted to include an increase reflecting an appropriate Consumer Price Index - Urban Wage Earners (CPI-U) for medical care; or

b. The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by an appropriate CPI-U; or

c. A TMA determined capped per diem set at the 75th percentile of all established TRICARE/CHAMPUS RTC rates nationally and weighted by total CHAMPUS days provided at each rate during the base period discussed above. The capped amount for TRICARE patients admitted on or after December 1, 1988, for services provided up through September 30, 1989, is **$355** per patient day.

2. The all-inclusive per diem rates for RTCs which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months of operation adjusted by the CPI-U, or the TMA determined capped amount. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated.

There will be no retroactive adjustment if the recalculated rate (based on 12 months of data) is higher than the initial rate (based on less than 12 months of data). The recalculated rate will become effective upon the date both parties sign off on a revised participation agreement. Until such time, the facility will be subject to the provisions and established rate set under the previous agreement.

3. The December 1, 1988, rate will be used in establishing the rebased amount for those RTCs failing to provide the necessary reimbursement information. It will be assumed that the RTC is satisfied with the all-inclusive rate implemented on December 1, 1988, for TRICARE beneficiaries admitted on or after December 1, 1988. The rate will be adjusted by an appropriate CPI-U and subject to the TMA determined capped amount.

4. For care on or after April 6, 1995, the per diem amount may not exceed the 70th percentile of all established fiscal year 1994 RTC rates nationally, weighted by total TRICARE/CHAMPUS days provided at each rate during the first half of fiscal year 1994, and updated to FY 95.

5. See Appendix A-1, Appendix A-2, Appendix A-3, Appendix A-4, Appendix A-5, or Appendix A-6 for a listing of approved RTCs and their rates.

B. All-inclusive Rate Concept.

1. TRICARE rates are all-inclusive and are established based upon data provided by each RTC. The all-inclusive per diem rate encompasses the RTC's daily charge for all RTC inpatient care and all mental health treatment determined necessary and rendered as part of the treatment plan established for the patient and authorized by the contractor. This includes all individual and group psychotherapy rendered to the RTC patient, family therapy rendered to the parents of the RTC patient within 250 miles of the facility, collateral visits with individuals other than the RTC patient determined necessary in order to gather information or implement treatment goals for the patient, and all other ancillary services provided by the RTC. The only charges that will be allowed outside the all-inclusive rate will be for: 1) geographically distant family therapy; 2) educational services not provided by other local, state or federal governments, and 3) non-mental health services (see below). Claims submitted by the RTC for residential treatment care will be paid based upon the rate established by the participation agreement. All other mental health claims submitted by other providers for services rendered to an RTC patient (except for inpatient claims as described below) will be denied. Other mental health providers may continue to render services to RTC patients under this payment system; however, such providers must look to the RTC for their payment. Noncovered charges for personal items (toiletries and clothing) are excluded.

2. The all-inclusive rate includes charges for the routine medical management of a beneficiary while residing in an RTC. Services provided by medical professionals employed by or contracted with the RTC are part of the all-inclusive per diem rate and cannot be billed separately. These routine medical services are made available to all children entering the facility and are designed to maintain the general health and welfare of the patient population. Examples of this type of care are: 1) routine health and physical examinations provided by RTC medical staff; 2) in-house pharmaceutical services; and 3) other ancillary medical services routinely provided to the RTC population.

3. Since the reimbursement methodology does not provide a direct payment mechanism for professional providers, except as prescribed in paragraph III.C., below, coverage cannot be extended for professional services rendered in a non-authorized RTC.

C. Charges Outside the All-Inclusive RTC Rate.

1. Geographically Distant Family Therapy. The family therapist may bill and be reimbursed separately from the RTC if the therapy is provided to one or both of the parents residing a minimum of 250 miles from the RTC. Family therapy must be authorized by the contractor for cost-sharing to occur.

2. RTC Educational Services. Payment of educational services is excluded except when appropriate education is not available from or not payable by other local, state or federal governments. TRICARE is always the payor of last resort. This is a proper role for TRICARE to play, in view of the fact that free education, including special education, is ordinarily available in local school systems. See Chapter 11, Section 12.1 of this manual.

3. Non-mental Health Services. Otherwise covered medical services related to a non-mental health condition and rendered by an independent provider outside the RTC are payable in addition to the all-inclusive per diem rate. This includes medical consultations,

laboratory tests, radiology and pharmaceutical services. Professional charges for medical visits or consultations must be billed by the independent professional provider. The remaining ancillary charges may either be billed by the independent provider or through the RTC. However, if the RTC is billing for the service, it must identify the provider by name, the related medical diagnosis and the specific medical procedure rendered. For example, if a child was injured while playing basketball, he or she might need medical care for the injury or suspected injury. Another example is where a child has a serious ear infection and must see an Ear, Nose and Throat Specialist. The specialist would bill TRICARE directly for his or her service. The medication prescribed by the specialist may be billed through the RTC as long as the provider is identified. The billing must also include the specific medical diagnosis along with the name and strength of the medication. However, if the medication is routinely dispensed out of the RTC pharmacy or nurses station it would fall under the all-inclusive rate. Services requiring admittance to another type of facility (i.e., acute mental or medical hospital) would be treated as a discharge from the RTC and payment for RTC services will be denied for the same period. Mental health treatment provided by an authorized TRICARE provider to a parent eligible for TRICARE coverage in his or her own right, and which is based upon the parent's own separately diagnosed Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) category, can be billed separately under the parent's name, even if the parent's treatment is occasioned by the RTC admission. This is true even if the parents reside at a distance from the RTC.

4. Claims for non-mental health services are to be cost-shared as inpatient if the contractor can not determine where the service was rendered and the status of the patient when the service was provided. The contractor would need to examine the claim for place of service and type of service to determine if the care was rendered in the RTC while the beneficiary was an inpatient of the RTC.

D. Authorization Requirements for RTC Care After July 31, 1988.

On or after August 1, 1988, contractors will provide four types of preauthorization for all admissions to RTCs.

1. Preauthorization and Concurrent Review. The contractor will obtain information necessary for review for residential treatment to assure that the level of care is medically necessary and appropriate. The contractor will issue an initial decision on authorization of an admission or continued care within three working days of receiving notification from a facility or family. A written decision will be sent to the facility, and parent or guardian.

a. If a patient is absent without leave (AWOL) for a period not to exceed 10 days, the facility must submit a staffing report.

b. If the period of time away from the facility is more than 10 days, admission approval is required including an updated treatment plan and progress report.

2. Authorization for Geographically Distant Family Therapy.

a. All geographically distant family therapy must be authorized and approved by the contractor at the time the treatment plan is submitted. The RTC is required to submit a detailed treatment plan for each TRICARE patient within 30 days of admission. The

authorization must be on file at the contractor before coverage can be extended. (Refer to Chapter 1, Section 12.8, Family Therapy.)

b. Cost-Share. Payment for geographically distant family therapy will be cost-shared on an inpatient basis, subject to the prevailing charge in the state in which the service was rendered.

3. Authorization for Coverage of Educational Services. A Public Official's Statement (POS) must be submitted to the contractor demonstrating that the school district in which the TRICARE/CHAMPUS beneficiary was last enrolled refuses to pay for the educational component of the child's RTC care. The contractor will review the Public Official's Statements on a case by case basis and make a decision on whether they meet the exception for coverage under the program. The authorization for educational services must be on file before coverage can be extended. (Refer to Chapter 11, Section 12.1.)

4. Authorization for Therapeutic Absences. Prior to July 1, 1995, all therapeutic absences must be planned and documented in the treatment plan submitted to the contractor for approval. Passes that do not involve an overnight stay away from the facility do not require specific authorization by the contractor.

a. Prior to July 1, 1995, all therapeutic absences required individual review by the CHAMPUS mental health review contractor, and an authorization submitted to the appropriate geographical contractor before payment could be made.

b. Therapeutic absences on or after July 1, 1995, may not be reimbursed.

E. Reimbursement of Therapeutic Absences.

1. Admissions on or After December 1, 1988. For all admissions on or after December 1, 1988, the first three days of each approved therapeutic absence will be allowed at 100 percent of the TRICARE all-inclusive rate. Beginning with the fourth day of a therapeutic absence, reimbursement will be at 75 percent of the rate.

2. Admissions Prior to December 1, 1988. For those RTCs that continue to participate under the terms of the new agreement, the contractors will continue to allow RTC charges for authorized therapeutic absences for patients admitted prior to December 1, 1988, at 100 percent of billed charges until the patient is discharged or transferred, or until the care is no longer determined medically necessary. RTCs that choose not to participate will be allowed RTCs charges for authorized therapeutic absences for patients admitted prior to December 1, 1988, at 100 percent of billed charges until the patient is discharged, transferred, or until January 31, 1989, whichever occurs first. If the patient is still in the RTC on February 1, 1989, coverage will cease.

3. Care on or after July 1, 1995. Therapeutic leave of absence days may not be reimbursed by TRICARE.

F. Dates Applicable to RTC Prospective Payment Methodology.

July 1, 1987 - June 30, 1988 - base period used in calculation of rebased individual RTC per diem rates and capped amount.

November 30, 1988 - beneficiaries admitted on or before this date are subject to the grandfathering provisions in paragraph IV.A. below.

December 1, 1988 - date that prospective payment rates went into effect for CHAMPUS beneficiaries admitted on or after December 1, 1988.

December 1, 1988 - September 30, 1989 - subject to retroactive adjustment of all claims for services provided CHAMPUS beneficiaries admitted on or after December 1, 1988, based on rebased per diem amounts (rates retired from Appendix A).

October 1, 1989 - updated rates for payment of claims for services rendered on or after October 1, 1989, for CHAMPUS patients admitted to RTCs on or after December 1, 1988 (rates retired from Appendix A).

October 1, 1990 - September 30, 1994 - updated rates for payment of claims for services rendered during this period have been retired from Appendix A.

October 1, 1994 - updated rates for payment of claims for services rendered on or after October 1, 1994 (refer to rates in Appendix A-1).

April 6, 1995 - updated rates for payment of claims for services rendered on or after April 6, 1995, (refer to rates in Appendix A-2).

October 1, 1995 - updated rates for payment of claims for services rendered on or after October 1, 1995 (refer to bracketed rates in Appendix A-3).

October 1, 1996 - updated rates for payment of claims for services rendered on or after October 1, 1996 (refer to bracketed rates in Appendix A-4).

October 1, 1997 - updated rates for payment of claims for services rendered on or after October 1, 1997 (refer to rates in Appendix A-5).

October 1, 1998 - updated rates for payment of claims for services rendered on or after October 1, 1998 (refer to rates in Appendix A-6).

IV. CONSIDERATIONS

A. Grandfathering Provisions.

1. RTCs that continue to participate under the terms of the new agreement will be reimbursed for CHAMPUS patients admitted up through November 30, 1988, on the same basis and at the same rates as were in effect prior to the December 1, 1988, effective date, until discharge or until the care is no longer determined medically necessary or appropriate by CHAMPUS in standard utilization and quality review procedures.

2. The grandfathering provision applicable to participating RTCs will be applied as follows:

a. Grandfathering will continue when a patient, otherwise eligible for the grandfathering provision, is discharged and admitted without any break from the RTC to a

hospital and directly back to the RTC. Any break (including a break of one day) in inpatient status nullifies grandfathering.

b. Any patient, otherwise eligible for the grandfathering provision, absent without leave (AWOL) for a period which exceeds 10 days shall lose grandfathering status.

c. In neither case (a or b above) will CHAMPUS cost-share any days of absence from the RTC.

B. Termination of Participation by RTC

1. Chapter 13, Addendum 6, Exhibit 1, Article 8 of the RTC participation agreement sets forth the following provisions for termination of participation under the TRICARE program:

a. Notice is not required for changes or modifications to the participation agreement resulting from amendments to the 32 CFR 199 through rulemaking procedures.

b. Changes or modifications resulting from amendments to the Regulation will become effective on the date the regulation amendment is effective or the date the agreement is amended, whichever date is earlier.

c. If the RTC does not wish to accept the proposed changes, it may terminate its participation by giving the agency written notice of such intent to terminate at least 60 calendar days in advance of the effective date of termination (Chapter 13, Addendum 6, Exhibit 1, Article 8 of the RTC participation agreement).

d. If the RTC's notice of intent to terminate its participation is not given at least 60 days prior to the effective date of the proposed changes / modifications, then the proposed changes / modifications will be incorporated into its agreement for care furnished between the effective date of the changes / modifications and the effective date of the termination of this agreement.

2. In other words, signing of the participation agreement simply acknowledges modifications / changes resulting from an amendment to the 32 CFR 199 through rulemaking procedures prescribed in Chapter 13, Addendum 6, Exhibit 1, Article 8 of the participation agreement. If the RTC does not want to participate, it can terminate its agreement by giving written notice 60 calendar days in advance of the effective date of the changes / modifications. However, in the interim, the RTC will be subject to the changes / modifications between the effective date of the changes / modifications and the effective date of termination of the agreement; i.e., 60 days from the notification of the RTC.

C. Retroactive Adjustment of RTC Claims.

1. Retroactive adjustment of RTC claims will only apply for those CHAMPUS patients admitted on or after December 1, 1988. CHAMPUS patients admitted prior to December 1, 1988, will not be affected by the rebasing and will continue to participate under the same conditions and rates as were in effect prior to the December 1, 1988, effective date, until discharge or until the care is no longer determined medically necessary or appropriate.

2. If the rebased rate is higher than the rate originally established on December 1, 1988, the contractor will retroactively adjust all claims for patients admitted on or after December 1, 1988, for services provided up through September 30, 1989.

a. A retroactive payment will be required if payments were made at a lower per diem rate. This payment will be the result of an adjustment based upon each claim processed during the retroactive period for which an adjustment is needed, and will be subject to the 21-day time frame for processing adjustments.

b. The retroactive adjustment will reflect the difference between the total amount that would have been paid to the RTC for those patients admitted on or after December 1, 1988, had the rebased rates been in use from December 1, 1988, through September 30, 1989, and the total amount that was paid based on the December 1, 1988, per diem rates.

c. In those situations where an RTC's per diem rate is adjusted upward as a result of the rebasing and payment was originally made at a lower per diem, the contractor is responsible for ensuring that the EOB to the beneficiary is suppressed to insure the beneficiary is not held responsible for additional payment(s).

d. The beneficiary and Federal Government will be held harmless for any additional cost-sharing beyond that determined initially for claims originally paid at the lower per diem amount. A message will appear on the provider's EOB prohibiting collection of additional cost-sharing as a result of rebasing. (Refer to OPM Part Two, Chapter 1, Section VI.H.3.d.(22)(c).)

e. Increases in cost-sharing will not be applied toward the catastrophic limit since there is no additional liability to the beneficiary.

3. RTCs may provide lists of CHAMPUS beneficiaries admitted to their facilities on or after December 1, 1988, to facilitate the identification of claims requiring retroactive adjustment; however, each claim must be verified prior to adjustment/payment.

D. If rebasing results in a per diem rate lower than the per diem rate implemented on December 1, 1988, a retroactive adjustment will not be required and no recoupment action will be initiated.

E. The goal of preauthorization and concurrent review for residential treatment is to assure that the RTC level of care is medically necessary and appropriate, that a reasonable and specific treatment plan is developed and carried out, and that the length of stay is as brief as is consistent with the needs of the individual TRICARE/CHAMPUS beneficiary.

F. Payment for RTC care will be made by the contractors only for claims from authorized RTCs, with proper authorization for care on file.

G. Updated RTC Rates.

1. Once a statistically valid rate is established for each RTC from the base year data (July 1, 1987 through June 30, 1988), it becomes the basis for all future rates. The change in mix of third party payor days thereafter will have no bearing on the TRICARE/CHAMPUS RTC per diem.

2. TMA will provide the contractors with annual rate updates prior to the start of each fiscal year. The RTC rates were updated on October 1 of each year using the annual CPI-U for medical care for the reporting period of the previous July to July. This reporting period was used due to the 2- to 3-month lag in publication of CPI-U statistics.

3. All claims reimbursed under the TRICARE/CHAMPUS RTC per diem payment system are to be priced for each day of service (using the rate in effect on the day of service) regardless of when the claim is submitted. Any adjustments to such claims will also be priced as of the day of service. In order to do this, contractors shall maintain at least three (3) iterations of per diem rates in the contractor's on-line system. If the claims filing deadline has been waived and the day of service is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest per diem rate on the contractor's system.

4. The rates in Appendix A-1 will be used for payment of claims for services rendered on or after October 1, 1994. The updated capped amount for services rendered on or after October 1, 1994, is $530 per patient day.

5. The rates in Appendix A-2 will be used for payment of claims for services rendered on or after April 6, 1995. The updated capped amount for services rendered on or after April 6, 1995, is $515 per patient day.

6. For fiscal years 1996 and 1997, the cap shall remain unchanged for any RTC whose 1995 rate was at or above the 30th percentile of all established fiscal year 1995 RTC rates normally weighted by total CHAMPUS days provided at each rate during the first half of fiscal year 1994. For any RTC whose 1995 rate was below the 30th percentile level as determined under this paragraph, the rate shall be adjusted by the lesser of the CPI-U for medical care, or the amount that brings the rate up to the 30th percentile level. For fiscal years after fiscal year 1997, the cap shall be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

7. The rates in Appendix A-3 reflect the rate adjustments for those RTCs whose 1995 per diems were below the 30th percentile of all established fiscal year 1995 rates. The rates were adjusted by the lesser of the CPI-U for medical care for the annual reporting period of July 1, 1994 to July 1995 (4.4 percent) or the amount that brought the rate up to the 30th percentile level of $429.

8. The rates in Appendix A-4 reflect the rate adjustments for those RTCs whose FY 1996 per diems were still below the 30th percentile of all established FY 1995 rates. The rates adjusted by the lesser of the CPI-U for medical care for the annual reporting period of July 1995 to July 1996 (3.6 percent) or the amount that brought the rate up to the 30th percentile level of $429.

9. As allowed by 32 CFR 199.14(f)(5)(iii), individual facility rates and cap amount are to be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment for fiscal years after FY 1997. Since the FY 1998 Medicare update factor is zero (0), individual facility per diems and cap amount will remain at previous FY 1997 levels. The rates in Appendix A-5 will be used for payment of services rendered on or after October 1, 1997. The cap amount for services rendered on or after October 1, 1997 will continue to be $515.

(For further information, see OPM Part Two, Chapter 1, Section IV.H.4.)

10. The rates in Appendix A-6 will be used for payment of claims for services rendered on or after October 1, 1998. The rates were adjusted by the lesser of the FY 1999 Medicare update factor (2.4 percent) or the amount that brought the rates up to the new cap amount of $528.

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